THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF WESTFORD

FY _____

APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION

Low Income Persons - Low or Moderate Income Seniors

General Laws Chapter 44B

Return to: Board of Assessors
55 Main St.
Westford, MA 01886

INSTRUCTIONS: Complete all sections that apply. Please print or type.

A. IDENTIFICATION Complete this section fully.

Name of Applicant _____ Telephone No. _____

Social Security Number _____ Date of Birth _____

Legal Residence as of Jan. 1st _____

Location of property: _____ No. of dwelling units 1 ____ 2 ____ 3 ____ 4 ____

Mailing Address (if different) _____

Did you own the property on Jan. 1st? _____ YES _____NO

If **YES**, were you :

____Sole Owner ____Co-Owner with Spouse only ____Co-Owner with Others

Was the property subject to a Trust as of Jan. 1st? _____ YES _____NO
(If YES, attach Trust Instrument including all schedules)

Have you been granted any exemption in any other city or town for this year? _____ YES _____ NO

If YES, name of city or town: _____ Type of Exemption _____

B. OTHER MEMBERS OF HOUSEHOLD AS OF JULY 1st

Full name of every one in the household (Jan 1, 2001)	Relation to Owner	Date of Birth	Occupation or school grade	Social Sec. Number
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

C. HOUSEHOLD OUT OF POCKET MEDICAL EXPENSES DURING PRECEEDING CALENDAR YEAR
List total medical expenses incurred by ALL household members during the calendar year before January 1 that were not paid by or reimbursed by an employer, public or private health insurance or other third party. Includes amounts paid in health insurance premiums, co-payments, deductibles and other out of pocket expenses. If you run out of space, continue list on attachment, in same format, as necessary. **Documentation may be requested to verify expenses claimed.**

Applicant (name) _____

TYPE OF EXPENSE	**TOTAL OUT OF POCKET FOR PRECEEDING CALENDAR YEAR**
Health insurance premiums	$_____
Doctors	$_____
Hospitals	$_____
Diagnostic Tests	$_____
Prescription drugs	$_____
Medical Equipment	$_____
Other	$_____
Total out of pocket	**$**_____

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Household member #1 (name) _____

TYPE OF EXPENSE	**TOTAL OUT OF POCKET FOR PRECEEDING CALENDAR YEAR**
Health insurance premiums	$_____
Doctors	$_____
Hospitals	$_____
Diagnostic Tests	$_____
Prescription drugs	$_____
Medical Equipment	$_____
Other	$_____
Total out of pocket	**$**_____

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Household member #2 (name) _____

TYPE OF EXPENSE	**TOTAL OUT OF POCKET FOR PRECEEDING CALENDAR YEAR**
Health insurance premiums	$_____
Doctors	$_____
Hospitals	$_____
Diagnostic Tests	$_____
Prescription drugs	$_____
Medical Equipment	$_____
Other	$_____
Total out of pocket	**$**_____

D. HOUSEHOLD GROSS INCOME DURING PRECEEDING CALENDAR YEAR - List income received from all sources for each member of household 18 and older, not full time student before January 1. Provide SIGNED copies of Federal Income Tax returns for ALL household members.

	APPLICANT (NAME)	MEMBER 1 (NAME)	MEMBER 2 (NAME)	MEMBER 3 (NAME)
TYPE OF INCOME				
Wages, salaries, other compensation	$	$	$	$
Social Security				
Other pension/retirement benefits				
Interest/Dividends				
Rental Income				
Net profits from business or profession				
Capital gains				
Alimony				
Child Support				
Public Assistance				
Unemployment compensation				
Disability compensation				
Other (specify)				
TOTAL GROSS INCOME (MEMBERS)	$	$	$	$
TOTAL GROSS INCOME (HOUSEHOLD)				$

E. SIGNATURE - Sign here to complete the application

This application has been prepared or examined by me. Under the pains and penalties of perjury, I declare that to the best of my knowledge and belief, it and all accompanying documents and statements are true, complete and correct.

_____ _____

Your Signature Date

If signed by agent, attach copy of written authorization to sign on behalf of taxpayer.

F. DISPOSITION OF APPLICATION (ASSESSOR'S USE ONLY)

Age _____ Ownership _____ Occupancy _____

Applicant 's Gross Income $ _____

Dependent Deduction $ _____

Medical Deduction $ _____

Applicant's CPA income $ _____

Co-Owner 2 Gross Income $ _____

Dependent Deduction $ _____

Medical Deduction $ _____

Co-Owner 2 CPA income $ _____

Co-Owner 1 Gross Income $ _____

Dependent Deduction $ _____

Medical Deduction $ _____

Co-Owner 1 CPA income $ _____

Co-Owner 3 Gross Income $ _____

Dependent Deduction $ _____

Medical Deduction $ _____

Co-Owner 3 CPA income $ _____

GRANTED _____ DENIED _____

Assessed surcharge $_____

Exempted Surcharge $ _____

Adjusted Surcharge $ _____

BOARD OF ASSESSOR'S

Date voted _____ _____

Certificate Number _____ _____

Date Notice sent _____ _____

_____

Date